Carteret Health Care - Patient Request for Health Information Form

Carteret Health Care recognizes a patient's right of access under HIPAA. There are charges associated with processing a request and producing requested records.

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):	
Street Address:	City:	State:	Zip:

What records do you want? (Check appropriate boxes below):

Date(s) of Service:____/____/____through_____/____/____

☐Provider Reports/Notes ☐Emergency Room Records ☐Operative/Procedure Reports ☐Billing Records

☐Test Results (X-Rays, Lab/Pathology Results) Please specify:_____

☐ Other (Immunization Records, Medication Lists) Please specify: _____

How would you like your records delivered? (Please note: There is a charge for copies of your medical record.)

☐Paper

☐Mail Delivery

☐In-Person Pickup

☐Electronic (DVD)

Where do you want the information sent? (Fill in boxes below):

Carteret Health Care should provide my records to: ☐Self ☐ Personal Representative (indicated below)

Recipient Name:	Recipient Phone: :
Recipient Mailing Address:	Recipient Fax :

Please print your name and sign below:

Name of Patient or Personal Representative (please print)	**Relationship to Patient (please print)**
Signature of Patient or Personal Representative	**Date/Time**

Please return completed form to: Carteret Health Care S*pecific Information Below*

	E-mail: **Fax:**
	Questions?

For internal use by Carteret Health Care only:

Patient Identification #:	*Date Received:*	*Date Processed:*	*Processed By:*
Fee Charged:	*Records Released to:*	*Date Released:*	*Released By:*